MONITORING QUALITY IN MEDICAID MANAGED CARE: ACCOMPLISHMENTS AND CHALLENGES AT THE YEAR 2000

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ABSTRACT This paper reviews the major developments during the late 1990s in quality monitoring for Medicaid managed care and offers an assessment of major challenges faced at the year 2000. We highlight the dramatic increase in activities to ensure and improve quality in Medicaid managed care. Prior to these developments, little was known about the actual level of quality of care. Thus, a major accomplishment of the late 1990s is that we now know more about quality, through some key indicators, and that states and plans have implemented activities and structures designed to improve quality. Despite this achievement, there is still a critical gap in our understanding about which activities and structures effectively improve the health of beneficiaries. There are also three operational challenges. First, as state quality assurance and improvement systems become increasingly comprehensive, states are challenged to keep them well coordinated and well targeted to key issues. Second, the dynamics of both plan turnover and enrollment—including steep drops in Medicaid enrollment—present a challenge for measuring and improving quality. A third challenge is to ensure that quality assurance and improvement programs work for enrollees with special health care needs. Finally, devoting sufficient resources to quality monitoring and improvement is a challenge for both states and plans since managed care programs are expected to save money as well as improve quality.

With over half of Medicaid beneficiaries now in Medicaid managed care, ensuring and improving quality and access for managed care enrollees is fundamental to the success of the Medicaid program.[1] In addition, more medically vulnerable beneficiaries with special health care needs now are enrolled in managed care programs, making quality monitoring all the more important.[2] Concerns about quality in Medicaid managed care stem from two main sources: the incentives inherent in capitated managed care for physicians to tend toward undertreatment

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and localized problems in places like Chicago and early scandals in California.[3,4] Knowing about the quality of care in individual health plans is also central to the concept of value-based purchasing, a paradigm that state Medicaid agencies are working to adopt.[5,6] In addition, managed care presents an opportunity for improvement because health plans can be held accountable for the health of their enrolled populations; in contrast, there is no locus for accountability in the fee-for-service system.

Spurred by these considerations, state Medicaid agencies increasingly used new tools that became widely available during the late 1990s to assist them in monitoring quality under Medicaid managed care. Federal expectations for quality monitoring also became more specific. As states continue to implement more comprehensive programs and to use the new tools, it is useful to review the major points of progress over the past few years and to assess future challenges. To that end, this paper provides background on the concept of "quality," reviews the policies that govern and the tools used for the monitoring Medicaid managed care quality in the late 1990s, reports on how these new policies and tools are being implemented, and discusses several major challenges still facing those who seek to ensure and improve the quality of care in Medicaid managed care.

BACKGROUND: QUALITY

After reviewing 100 definitions of quality, the Institute of Medicine in 1990 defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[7(voll, p21)] At present, quality monitoring for Medicaid managed care combines two concepts: continuous quality improvement (CQI) and quality assurance.

CQI emphasizes the ongoing improvement of performance and de-emphasizes whether a particular standard of performance has been met.[8,9] The major goal of CQI is to improve the overall performance of individuals and the organization. CQI also emphasizes the role of patient preferences and satisfaction in determining health outcomes. While actively supporting CQI, policymakers, advocates, and others still are concerned that a minimum acceptable level of quality be ensured. Thus, current strategies for monitoring managed care quality tend to combine requirements for managed care structures and processes that are believed to be important to ensuring adequate quality with standards that promote and monitor quality improvement as well. Measuring quality is essential both to ensure adequate quality and to assess improvement.

In this paper, we focus on activities aimed specifically at ensuring and improv-

ing quality of care in Medicaid managed care, although we recognize that many things affect quality—things as basic to Medicaid programs as payment policy and coverage, health behaviors and attitudes of the Medicaid population, and behaviors and attitudes of participating providers.

POLICIES AND TOOLS FOR MONITORING QUALITY IN THE LATE 1990s

Federal guidance on Medicaid managed care quality evolved substantially during the late 1990s. Historically, federal requirements for quality assurance in Medicaid have been general, but the Balanced Budget Act of 1997 (BBA) and the proposed rules that followed it have changed that as federal policy became much more specific about the systems and processes that must be in place to ensure and improve quality. Prior to the BBA, a growing number of state Medicaid agencies were seeking and receiving Section 1115 and 1915(b) waivers, in part to allow them to establish mandatory managed care programs. With these waivers came additional federal requirements for quality systems, but the additional requirements were not standard across states until the BBA.

In addition, the Health Care Financing Administration (HCFA) developed interim quality assurance standards under a major initiative called a Quality Improvement System for Managed Care (QISMC). These standards offer more specific guidance to state Medicaid agencies on quality standards that should be met by managed care organizations (MCOs).[10] QISMC standards were designed to apply to MCOs serving in either Medicaid or Medicare; at present, the standards are optional for state Medicaid programs, but mandatory for MCOs that serve Medicare. The standards both require administrative structures and processes that promote quality and describe what constitutes an acceptable quality assessment and performance improvement program. QISMC standards build on another HCFA-led effort, the Quality Assurance Reform Initiative (QARI), which represented the first definition of a state-based quality improvement system for Medicaid managed care. The QARI system, implemented in a demonstration in three states during 1993–1996, was adopted by some other states during the same time period.

In addition to the evolution of the Medicaid managed care oversight structure, major new tools became available for monitoring quality. One important new tool is a validated Medicaid version of the Consumer Assessments of Health Plans (CAHPS) survey, designed to provide consumer ratings of health care.[11] A second important tool is the continually evolving Health Plan Employer Data and Information Set (HEDIS), which specifies indicators for effectiveness of care

for access to care and utilization and for other dimensions of care and service.[12] A third new emerging tool, benchmark data, is helpful for states using HEDIS and CAHPS.

Beyond these tools, accreditation has remained a mechanism for ensuring quality in managed care plans. However, while the use of accreditation among large employers purchasing managed care grew during the 1990s, the same trend is not apparent among Medicaid agencies, and many Medicaid-dominant plans—particularly the smaller ones—have not sought accreditation to date.

We describe below each of the major policies and tools for monitoring quality and follow with a brief review of the role of accreditation in quality monitoring. The following major policies are used for oversight and guidance:

- The BBA and Proposed Rules Related to Quality Assessment and Improvement. The new law and rules are changing the overall structure of Medicaid managed care oversight.
- QISMC Interim Standards for MCOs. These standards were developed by HCFA to set expectations for health plans serving Medicaid or Medicare beneficiaries. State Medicaid agencies may adopt or adapt the standards.

The following tools are used for monitoring quality:

- HEDIS. This set of measurement and information specifications is an important quality measurement tool that is being used increasingly by state Medicaid agencies to assess quality.
- CAHPS. This newly available set of survey and reporting tools is designed to produce consumer ratings of health care.
- FACCT (Foundation for Accountability). FACCT has developed several consumer survey tools for people with chronic illness and has developed sets of measures for specific conditions.
- Benchmarks. Some benchmarks for both HEDIS and CAHPS have been identified; these tools allow an organization or state to compare its performance to the performance of others.
- Accreditation. Accreditation remains a tool that states can use to set expectations for MCO quality assurance and improvement activities.

Oversight Structure

Balanced Budget Act of 1997 and Proposed Rules Related to Quality Assessment and Improvement The BBA and related Proposed Rules essentially replace a quite limited set of federal requirements for quality assurance with the first federal

requirement for a state-based comprehensive strategy for quality assessment and improvement for Medicaid managed care.

Prior to the BBA, the federal government relied heavily on the proxy for quality known as the "75/25 rule." With some exceptions, this rule required an MCO serving Medicaid enrollees to have no more than 75% of its enrollment composed of Medicare and Medicaid enrollees. The assumption was that private employers and employees would avoid poor-quality plans, thus screening out poor-quality plans from the Medicaid market as well. The BBA eliminated the 75/25 rule in Section 4703 and in its place required state Medicaid agencies to have a comprehensive strategy for assessing and improving the quality of managed care services in MCOs (Section 4705). This change also gave the Secretary of Health and Human Services the authority to define "adequate strategy."

The BBA continues the long-standing requirement that states arrange for an independent, external review of the quality of services furnished by each contracted MCO (BBA, Section 4705). It also gave the Secretary of Health and Human Services responsibility for further specifying the external review process, opening the door for more flexibility for states in meeting this requirement.

To meet its obligations under the BBA, Health and Human Services[13,14] issued two sets of proposed rules that changed the face of Medicaid managed care oversight. At this writing, neither set of rules is final. Figure 1 summarizes the major quality-related provisions of the BBA and the two sets of proposed rules.

The important change made by the BBA to the external quality review process was to expand the types of organizations with which a state may contract to perform external review while specifying minimum criteria for the competence and independence of such organizations. This approach is designed to allow states more flexibility in contracting with organizations that are best suited to an increasing diversity of quality review activities (discussed in more detail below). In addition, HCFA has sponsored the development of protocols for external review (not yet released), which will contain specific methodologies for review; the external quality review processes for the states will be required to be consistent with these protocols. The protocols should help to address historic problems with the methodologies used in some of the review studies, thus increasing the value of the reviews.[15]

Quality Improvement System for Managed Care Interim Standards for Managed Care Organizations QISMC standards for quality in managed care organizations were specified in considerable detail under an HCFA initiative during 1996–1998. The

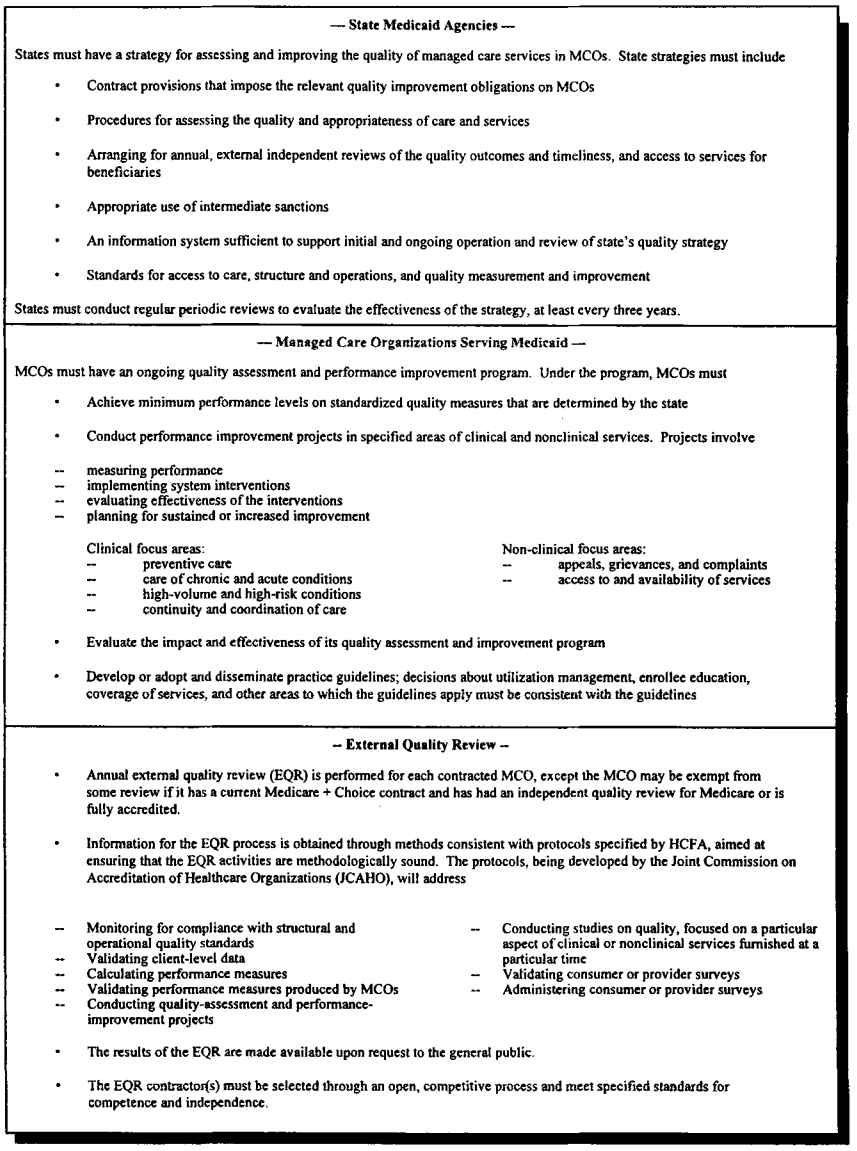

FIGURE 1 Summary of BBA-related proposed rules for monitoring of Medicaid managed care quality.

National Academy for State Health Policy led the development of these standards; the development included consultation with a broad spectrum of groups.

The QISMC standards direct an MCO to[16]

- Operate an internal program of quality assessment and performance improvement that achieves demonstrable improvements in enrollee health, functional status, and satisfaction across a broad spectrum of care and services

- Collect and report data reflecting its performance on standardized measures of health care quality and meet such performance levels on these measures as may be established under its contract
- Demonstrate compliance with basic requirements for administrative structures and operations that promote quality of care and beneficiary protection.

QISMC standards and guidelines are in effect nationally for the Medicare program, but remain optional for state Medicaid programs. The standards are consistent with BBA requirements and proposed rules and thus may be used by states as a tool for complying with the BBA. Figure 2 provides an outline of the major areas covered by QISMC.

QISMC standards do not dictate the use of specific measurement tools such as HEDIS or CAHPS (discussed below), but its call for performance measurement gives states the authority and justification to use these tools at their discretion.

I. Quality Assessment and Performance Improvement (QAPI) Programs in MCOs

Basic Requirements

- Achieve minimum performance levels
- Conduct performance improvement projects in major focus areas of clinical and nonclinical care
- Correct significant systemic problems

Performance Improvement Projects

- Two-year phase in
- Timeframes for achieving demonstrable improvement (demonstrable and sustained improvement are defined)
- Clinical and nonclinical focus areas are specified
- Projects follow guidance on method for selecting topics, using quality indicators, and collecting data

Health Information System that supports the QAPI program

Administration of the QAPI program

- Clear and appropriate administration of program (defined)
- QAPI program is evaluated annually

II. Enrollee Rights

Written organizational policies that are communicated, monitored, and actively promoted

Enrollee rights (specified in QISMC)

Enrollee information (specified in QISMC)

System for resolving issues raised by enrollees

- Procedures for receipt and processing of issues
- Procedures for resolving complaints and grievances
- Procedures for reviewing requests to reconsider coverage or payment decisions
- Monitoring of the issues resolution process

FIGURE 2 QISMC standards for managed care organizations serving Medicare and Medicaid beneficiaries. *Source*: summarized from http://www.hcfa.gov/quality/docs/qismc/.2Ds.htm.

III. Health Services Management

Availability and accessibility

- Network adequacy
- Medically necessary services available 24 hours/7 days per week
- Cultural competence
- Standards are set for timeliness of access
- Policy encouraging provider consideration of beneficiary input in treatment plan

Continuity and Coordination of Care

- Use of a primary care provider
- Programs for coordination of care
- Procedures for timely communication of clinical information and providers

Service Authorization

- Policies and procedures to process requests for authorization
- Information to providers on enrollee benefits

Practice Guidelines and New Technology

- Adoption and dissemination of practice guidelines
- Policies and procedures for evaluating new technology

Provider Qualification and Selection

- Credentialing and recredentialing for physicians, other licensed health professionals, and institutional providers or suppliers

Enrollee health records and communication of clinical information

- Initial assessment of new enrollee's health within 90 days of enrollment
- Health records meet standards
- Appropriate and confidential information exchange among providers
- Policies and procedures for sharing enrollee information with any organization with which enrollee subsequently enrollees

IV. Delegation

Oversight and accountability for functions described in Domains I-III that are delegated to other entities

If there is delegation of selection of providers to another entity, MCO retains rights to approve, suspend, or terminate those providers

FIGURE 2 Continued.

TOOLS FOR MONITORING QUALITY

Health Plan Employer Data and Information Set HEDIS is a set of measurement and information specifications for managed care that includes quality and access measures applicable to the Medicaid population. HEDIS is thus an important measurement tool that can be used by states and plans in a comprehensive quality improvement strategy. HEDIS is updated annually by the National Committee for Quality Assurance (NCQA) in consultation with others. The update process generally is conservative in terms of changing existing measures, reflecting the belief that continuity is needed to show changes in performance from one year to the next. HEDIS measures for Medicaid were developed first by a consortium of public and private organizations, led by NCQA. This set of Medicaid measures,

known as Medicaid HEDIS, then was incorporated into HEDIS 3.0, which was released by NCQA in January 1997. Since then, HEDIS has applied to Medicaid, Medicare, and commercial populations. Figure 3 lists the effectiveness-of-care and access measures that apply to the Medicaid population in the year 2000. The development of HEDIS and the important contribution of Medicaid HEDIS to the current usefulness of HEDIS for the Medicaid population has been described elsewhere.[17,18]

Consumer Assessment of Health Plans Survey CAHPS is a set of survey and reporting tools designed to assist purchasers and consumers in assessing and choosing among MCOs.* The survey set includes two surveys specifically designed for adults and children in Medicaid managed care. (Medicaid fee-for-service versions are also available for adults and children.) Topics covered by the Medicaid managed care CAHPS surveys are listed in Fig. 4. The survey kit also includes sample formats for reporting results to consumers, software to assist in data analysis, and guidance and instructions. Supplemental questions were also developed for optional use in conjunction with the "core" questionnaires. These questions cover such topics as communication, interpretation, dental care, behavioral health, chronic conditions, pregnancy care, prescription medicine, transportation, Medicaid enrollment, and a few questions relevant to HEDIS.

Continuing Measures	
Childhood immunization status	Cholesterol management after acute cardiovascular events
Adolescent immunization status	Comprehensive diabetes care
Breast cancer screening	Follow-up after hospitalization for mental illness
Cervical cancer screening	Antidepressant medication management
Prenatal care in first trimester	Advising smokers to quit
Check-ups after delivery	
Beta blocker treatment after a heart attack	
New Measures (Year 2000 is First Year Measure is Included in HEDIS)	
Chlamydia screening in women	
Controlling high blood pressure	
Use of appropriate medications for people with asthma	

FIGURE 3 Topics covered by HEDIS effectiveness-of-care measures applicable to the Medicaid population in the year 2000. Note: Other HEDIS measures are also relevant to quality of care even though they are not listed in the effectiveness-of-care section of HEDIS. These include HEDIS/CAHPS survey results on satisfaction with care for adults and children and access/availability of care measures such as initiation of prenatal care, children's access to primary care practitioners, and annual dental visits. *Source*: available online at http://www.ncqa.org/pages/policy/hedis/h00meas.htm.

*CAHPS, sponsored by the Agency for Healthcare Research and Quality, was developed by consortia headed by the Harvard Medical School, the Research Triangle Institute, and RAND.

Your personal doctor or nurse

Change in provider
Any problem getting one you are happy with
Sense of having a personal doctor or nurse
Rating from worst to best

Getting health care from a specialist

Any problem getting a referral
Rating of specialist from worst to best

Calling doctors' offices

How often got the help and advice needed

Your health plan

Any problem finding or understanding information in written materials
Any problem getting help from customer service
Any problem with paperwork from the plan
Rating of health plan worst to best

Your health care in the last 6 months

Ability to get care as soon as you wanted for routine condition
Ability to get care as soon as you wanted for urgent condition
Use of emergency room
Any difficulty getting care you or doctor believed necessary
Any delays in health care while waiting for plan approval
How often doctors or other providers listened to you
Any language difficulty
Ability of providers to explain things clearly
How often doctors or other providers spent enough time with you
Rating of health care worst to best
Need for and ability to get an interpreter

About You

Rating of overall health, excellent to poor

FIGURE 4 Topics covered by CAHPS core surveys for Medicaid managed care for adults. (The child Medicaid managed care questionnaire covers similar topics. It also includes some questions about receiving reminders for checkups or shots; how often the doctor talked to you about how the child is feeling, growing, and behaving; and whether the child has any kind of emotional, developmental, or behavior difficulty for which he or she has received treatment or counseling.) Note: The descriptors listed under each topic heading were selected for this paper and are meant to be illustrative, but are not complete or literal; please refer to the questionnaires for complete information. *Source*: CAHPS 2.0 Survey Instruments, AHRQ 1998.

Foundation for Accountability FACCT has developed survey tools and sets of measures that are focused primarily on chronic illnesses and are intended to be more outcome oriented than those of HEDIS. There are FACCT measurement sets for adult asthma, alcohol misuse, breast cancer, diabetes, major depressive disorder, health status, health risks, and consumer satisfaction.[19] Some of the measures produced by FACCT appear to be more information intensive than HEDIS measures. For example, FACCT calls for the assessment of quality related to care for breast cancer patients to include the following: a survey of patients at 3–6 months and again at 12–15 months after diagnosis, an assessment of patient satisfaction and experience; the calculation of survival rates as a function of stage of disease and type of treatment and other items that may be collected from a cancer registry; and the use of administrative data to identify regular testing for breast cancer. FACCT has also developed a survey tool kit that includes three patient surveys for adults (concerning asthma, coronary artery disease, or diabetes); instructions for implementing the surveys; and performance measures that structure interpretation and help clients use the survey data.

In addition, FACCT has developed a "consumer information framework" to

organize comparative information on quality into five categories based on research about how consumers think about their care: the basics, staying healthy, getting better, living with illness, and changing needs. The goal is to create a common structure and language for quality comparisons.

Benchmarks Benchmarks, performance measurement results that allow one to compare one's own health care experience to that of others, are beginning to become available. They can be used as a tool for state Medicaid agencies in the attempt to interpret the results of quality measurement for managed care in their state. The benchmark data are also an important source of information for national policymakers, researchers, and others seeking to understand the variations and trends in health plan performance. We focus here on the two major sources of benchmarks most directly applicable for the Medicaid population, the National Medicaid HEDIS Database/Benchmark Project and the CAHPS Benchmarking Database. Other sources of benchmarks that do not focus specifically on Medicaid (such as NCQA's Quality Compass, which contains HEDIS data voluntarily submitted by health plans) are also available, usually for purchase.

The National Medicaid HEDIS Database/Benchmark Project now has 2 years of HEDIS data for the Medicaid population for selected HEDIS indicators (American Public Human Services Association [APHSA], National Medicaid HEDIS Database/Benchmark Project: Benchmarks for Measurement Year 1998, fax, April 2000). The results for the second year (data for 1998), which are believed to be more reliable than results for the first, include 180 plans located in 29 states and Puerto Rico. Means for benchmark indicators for the second year are shown in Table I. A report explaining the analysis should be available in fall 2000 from the Commonwealth Fund or APHSA. Although the availability of the Medicaid HEDIS benchmark database is a great step forward, at present only some of the submitted data are audited. Self-reported HEDIS data that have not been audited may be viewed as less reliable. APHSA has also compared MCO performance in Medicaid to MCO performance for commercial coverage on the selected indicators. However, the fact that Medicaid data reporting is usually mandatory while commercial reporting has been voluntary introduces a bias that is like to favor the commercial plans.

The CAHPS Benchmarking Database includes CAHPS results for Medicaid agencies, public and private employers, and individual health plans. In 1999, 28 participating sponsors submitted CAHPS data that covered 500 health plans.[20]

Role of accreditation in Medicaid managed care quality Large private purchasers often use accreditation as a major vehicle for ensuring quality of care in health

TABLE 1 National Medicaid HEDIS Database Benchmark Data for 1998 (Selected Measures)

Measure	Description	25th Percentile	Median	75th Percentile	Mean
Childhood immunization status	Percentage of children who reached age 2 in the reporting year who received all 12 recommended immunizations	44	54	61	53
Adolescent immunization status	Percentage of children who turned 13 in the reporting year who received the recommended second MMR immunization	26	54	64	46
Cervical cancer screening	Percentage of women age 21 through 64 years who received one or more Papanicolaou tests during the past 3 years	48	63	75	60
Checkup after delivery	Percentage of women who had a postpartum visit 3 to 8 weeks after delivery	37	48	56	46
Eye exams for people with diabetes	Percentage of members age 31 years or older with diabetes who received a retinal eye exam in the reporting year	28	38	49	38
Children's access to primary care providers	Percentage of children who saw a primary care provider during the year				
Ages 12 to 24 months		74	89	95	83
Ages 25 months to 6 years		63	77	86	73
Ages 7 to 11 years		64	77	88	74
Well child visits	Percentage of children aged 3–6 years who received one or more well child visits with a primary care provider during the year	42	52	63	51
Prenatal care in first trimester	Percentage of women who delivered a live birth during the reporting years and had a prenatal care visit 26–44 weeks prior to delivery	49	61	71	59
Adolescent well care visits	Percentage of members aged 12–21 years who had at least one well care visit with a primary care provider during the year	20	26	36	27

Source: American Public Human Services Association, Benchmarks for Measurement Year 1998 (Reporting Year 1999), 2000. The project to develop these benchmarks was funded by the Commonwealth Fund.

maintenance organizations (HMOs). In some markets, such as Massachusetts and southern California, NCQA accreditation essentially was a "minimum ticket for participation" in the HMO market during the late 1990s. A 1998 survey of employers found that 28% of the larger employers that offer HMO coverage requested or required NCQA accreditation.[21]

NCQA accreditation standards evolved during the 1990s. In essence, they are detailed standards that require both that plans have certain quality improvement processes and structures in place and that plans be able to demonstrate improvement in focus areas that cover a range of clinical care and are appropriate to the population of the plan. For the first time, in the year 2000, NCQA is reviewing HEDIS data of the plans as part of the accreditation process. To get the highest level of accreditation—excellent—a plan now needs to demonstrate high performance on HEDIS and to comply with the other standards.

In addition to NCQA, other organizations, including the Utilization Review Accreditation Commission (also known as the American Accreditation HealthCare/Commission) and the Joint Commission on Accreditation of Healthcare Organizations (see their web sites [www.urac.org and www.jcaho.org, respectively] or contact them directly for more information), are offering accreditation for health plans, although NCQA has been the dominant accreditation organization to date for HMOs.

Accreditation may be helpful to state Medicaid agencies in several ways. States can use accreditation standards as a reference when deciding what to require of MCOs, and many have done so already.[22] As a way to set expectations for MCO quality improvement activities, states could encourage or require that plans work to obtain accreditation. Eight states require health plans serving Medicaid to become accredited (Florida, Iowa, Indiana, Kentucky, Michigan, Nebraska, Pennsylvania, and Virginia).[22] Also, many of the QISMC standards are similar to NCQA standards, so plans that meet NCQA requirements probably will not have difficulty meeting many of the QISMC standards.

Potential barriers to increased use of accreditation in Medicaid managed care include its cost, particularly for small, Medicaid-dominated plans; the desire of states to examine compliance with state-specific requirements; and the preference of some plans to keep NCQA survey information confidential.

IMPLEMENTATION OF THE NEW POLICIES AND TOOLS

Quality-monitoring activities by state Medicaid agencies greatly expanded during the mid-1990s to late 1990s as state managed care programs grew and the various policies and tools discussed above emerged. This also reflects a shift in state

focus from basic program implementation to program improvement as state managed care programs have matured.[22,23] Recent reports and survey results show that states have worked to strengthen their quality-monitoring processes in at least four ways:

1. By making contract and reporting requirements faced by MCOs more specific.
2. By taking advantage of new tools such as HEDIS and CAHPS.
3. By expanding the types of the quality-monitoring activities they perform or that they arrange to have performed.
4. In some cases, by extending quality improvement and monitoring programs to primary care case management programs (PCCMs).

States still vary widely in their approaches to quality monitoring, as might be expected given the diversity of state programs and histories.[23] At one extreme, some states take a "partnership" approach with MCOs, in which sanctions are rare, and continuous feedback, assistance, and negotiation of issues are the primary methods for monitoring. In such states, improvement is required and monitored, but plans are not always held to performance standards. Other states (such as Tennessee) have taken more of a "regulatory" approach, in which the enforcement of standards is emphasized, and penalties are imposed when plans do not meet performance standards or do not set or follow acceptable "corrective action" plans. An example of an enforcement approach is New Jersey's policy that withdraws a half-month capitation fee for each calendar day after a 5-day grace period that the department does not receive an acceptable corrective action plan from the MCO.[24]

Making Contract and Reporting Requirements Faced by Managed Care Organizations More Specific

An annual analysis of the contracts of states with MCOs suggests that states have been adding provisions related to quality to these contracts or to their Requests-for-Proposals (RFPs).[24,25] For example, in 1998, slightly more than half the states studied included both clinical studies and clinical guidelines in their quality assurance system, a significant increase from 1997. The study also found a significant increase from 1997 in the number of states requiring plans to report access, outcomes, and performance data, with more than twice the prior year's number of states (12 of 30) requiring outcomes data.

Yet, there remains large variation among states in how specific the quality-related requirements are on almost every dimension. For example, states vary in how they define the conditions or diseases to be studied by an MCO. A North

Carolina contract identifies the conditions/diagnoses to be monitored, while Massachusetts requires the MCO to identify "three key clinical . . . quality improvement projects" to be undertaken. Other states (such as Florida) require studies on "at least 5 of the clinical areas of concern" (which are then listed).[24] The specifics of requirements for clinical guidelines also vary, with some states simply requiring the MCO to have clinical guidelines, and others including detailed requirements for how the MCO should disseminate the guidelines to providers and how they should monitor providers to ensure compliance with the guidelines.

Taking Advantage of New Tools

States have started to collect some of the HEDIS measures that are applicable to Medicaid. The National Medicaid HEDIS Database/Benchmark Project, for example, obtained 1998 HEDIS data on at least a few selected quality measures for 180 plans (APHSA, National Medicaid HEDIS Database/Benchmark Project: Benchmarks for Measurement Year 1998, fax, April 2000). Many states appear to be selecting from the list of HEDIS measures rather than collecting (or requiring) the full set of applicable HEDIS measures in any given year. An APHSA survey found that, by mid-1998, 28 of 44 states with risk programs (64%) were using or planning to use at least some HEDIS measures to monitor plan performance.[17] The quality measures most frequently used that year were childhood immunization status (24 states), prenatal care in the first trimester (22), and cervical cancer screening (21). Several other measures were fairly common (each used by 14 to 18 states): checkups after delivery, breast cancer screening, eye exams for people with diabetes, and adolescent immunization status. Fewer than 10 states used other measures of effectiveness of care.

Plans and states undoubtedly made a substantial investment in producing HEDIS Medicaid data in the mid-to-late 1990s since earlier problems in producing HEDIS data were significant.[26] Though standardized measures of quality for the Medicaid population have become more available, there is clearly room for improvement in state use of HEDIS and for more measures. But, producing HEDIS measures is a time- and resource-intensive effort for plans and/or states. Moreover, as the demand for measures and information grows, states and plans both will be constrained in the resources they have to produce these data. At best, they will have to balance the need for resources for this activity with the need to support other quality improvement and measurement efforts.

States have also begun using CAHPS for Medicaid. In mid-1998, 20 states reported that they had implemented a CAHPS survey in their risk-based managed

care programs. A number of these efforts appear to be simultaneous surveys of Medicaid managed care and Medicaid fee-for-service beneficiaries, Medicaid and commercial enrollees, and/or Medicaid full-risk managed care and Medicaid PCCM enrollees, thus offering states the ability to compare results for different Medicaid subpopulations or between Medicaid and commercial enrollees (see examples cited in Ref. 27).

FACCT tools have also been used by several state Medicaid agencies, including Iowa and Michigan (see web site at http://www.facct.org).

Expanding Quality-Monitoring Activities

As states adopted more comprehensive quality improvement programs during the mid-1990s and late 1990s, they have expanded the types and intensity of quality-monitoring activities that they perform or arrange to have performed. An evaluation for HCFA of Medicaid waiver programs in five states from 1994 through 1998 showed that, while implementing a comprehensive quality improvement program is a gradual process, it prompted states to conduct many types of monitoring activities. For example, Wooldridge and Hoag[23] reported that, to verify plan compliance with contract standards, these states monitored plans through the following activities:

- Reviewing written materials (e.g., the content of quality assurance programs, minutes from the medical directors' meetings, and credentialing committee reports) and studies conducted by plans
- Interviewing and/or holding regular meetings with the medical directors and quality improvement staff
- Comparing review findings with previous findings to assess quality improvement
- Comparing findings against the state standards for each area covered by the quality assurance program
- Providing feedback to the plans and requiring corrective action for noncompliance

External quality review activities have also become more extensive in many states. During the early to mid-1990s, the emphasis of the external quality review shifted from often limited, problem-focused medical record reviews to population-based studies that focused on specific clinical areas of interest, known as clinical focused studies.* More recently, the trend appears to be moving away

*Kaye and Pernice[22] showed that the number of states with risk-based programs reporting that their external quality review organizations performed focused medical record reviews rose from 18 states (56%) in 1994 to 30 states (79%) in 1996.

TABLE II State Quality-Monitoring Activities in Risk-based Medicaid Managed Care Programs*

Activities Performed by States or Contracted External Quality Review Organizations	Number of States, 1998
State review/audits on site	31
Desk review/audit	27
Focused study	34
Random medical record review	40
Enrollee survey/focus groups	42
Disenrollment survey	20
Monitor voluntary disenrollment	40
Provider survey/focus group	28
Required accreditation	8
Performance measure validation	23

Source: The National Academy for State Health Policy, *Medicaid Managed Care: a Guide for States*, 4th ed., 1999.

*The National Academy for State Health Policy also reports that 38 states had an enrollee hotline, and 25 states had an ombudsman program; both those activities would serve as information sources for the quality improvement program.

from clinical focused studies toward a wider range of activities.[28] In addition to contracting for regular monitoring by an external quality review organization (EQRO), which is usually a peer review organization, all seven states studied in 1998 by the Department of HHS Office of the Inspector General had contracts in the past 2 years with other types of organizations to perform quality oversight activities that ranged from administering consumer surveys to conducting specialized focus groups, from validating claims data to monitoring drug utilization, and from monitoring length of stay in mental health facilities to conducting preadmission screening for hospitalizations.[29]

Table II shows the number of states that had various types of quality-monitoring activities identified by 1998 survey of the National Academy for State Health Policy.

Extending Quality Improvement and Monitoring Programs to Primary Care Case Management Programs

Many states have been working toward managing their PCCM programs as though they were MCOs by, for example, applying some aspects of their quality improvement programs. PCCM programs are fee-for-service managed care programs that do not involve MCOs. Typically, states contract directly with primary care providers, who receive a fee for service plus a case management fee in exchange for serving as an enrollee's medical home. Smith and colleagues[30]

described how some states have applied managed care–type quality improvement efforts successfully in these programs. For instance, some states have included the following in their PCCM procedures:

- A formal quality improvement process that includes clinical focus areas such as breast cancer screening, asthma management, and immunization rates; quality improvement projects are often carried out at a local level or with specific provider practices (e.g., Arkansas, Massachusetts, North Carolina).
- The collection and reporting of HEDIS data, which allows comparison to health plan performance (e.g., Arkansas, Colorado, Oklahoma, Massachusetts).
- Disease management initiatives (e.g., Virginia, Massachusetts, Arkansas, Texas, North Carolina, Florida). Florida, for example, contracted in 1999 for management of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), asthma, diabetes, and hemophilia, and the state planned to expand these efforts to congestive heart failure and end-stage renal disease.

FUTURE CHALLENGES

Meeting the Implementation Challenge

As state systems for monitoring quality have become increasingly comprehensive, a major challenge is to operate a comprehensive system that is well coordinated and well targeted. The need for multiyear planning and for coordinating and using increasing amounts of information was highlighted by the experience of the three states that participated in the demonstration of QARI (the precursor to QISMC).[15]

Coordinating a quality-monitoring system becomes more challenging as activities are added in any given year and as more entities and individuals are involved. In a well-coordinated system, the results of the various activities should come together such that a state can identify problems in a particular plan, geographic area, or population subgroup and such that the burden of various activities on plans is distributed over time rather than over a few months. The many points of data on quality that flow to the state from various sources should be synthesized and used in a well-coordinated program.

In a well-targeted system, monitoring activities focus on the health care issues key to a certain state. A well-targeted system is also cost effective and should not discourage plans from participating. It is not reasonable to expect a state or plans to monitor all the important aspects of quality in any given year, so as

systems expand, thoughtful multiyear planning of quality-monitoring and quality improvement projects becomes critical. This is particularly important since the administrative burden on plans has been cited as a reason for the withdrawal of many plans from the Medicaid market.[31]

Devoting Sufficient Resources to Quality Monitoring and Improvement

The costs of implementing comprehensive monitoring and quality improvement systems are substantial both for government and for the organizations and providers who must participate and comply with them.[15,23] Yet, both state and federal policies typically expect savings from managed care programs over fee-for-service programs, constraining the resources that may be devoted to quality. For example, the federally specified "upper payment limit" for each state imposes a ceiling on program expenditures based on the historical costs of fee-for-service programs that typically did not include quality measurement or improvement processes. Therefore, the costs of quality measurement and improvement processes must be at least offset by savings from managed care (through reductions in emergency room services and hospitalizations, for example). Similarly, states typically set capitation rates to plans based on expected savings over fee-for-service rates, again assuming that savings from care management by plans can cover the increased costs of participating in quality-monitoring and improvement programs fully.

Accounting for Plan and Enrollee Turnover

The dynamics of plan turnover and enrollment changes—including steep drops in Medicaid enrollment—present additional challenges for measuring and improving quality in Medicaid managed care. A change—or lack of change—in a measured quality indicator from one year to the next may be more difficult to interpret if the population of a plan in one year is very different from that in the previous year, regardless of whether the change happened because, for example, a large portion of the plan's former enrollees dropped from the Medicaid program entirely or because a plan picked up a large new service area when another plan left the Medicaid market. Particularly, as the emphasis shifts from meeting a particular standard to demonstrating improvement from year to year, it will be important for states to determine how to handle major shifts (as opposed to modest shifts) without leaving a large proportion of beneficiaries out of the quality-monitoring process.

Ensuring that Measurement Works for Special Needs Populations

As quality improvement programs mature, and as more beneficiaries with special health care needs are included in managed care programs, attention should

focus more on whether quality improvement strategies and tools work well for beneficiaries with special needs. This is an important target issue for quality monitoring for at least three reasons:

1. These beneficiaries are particularly vulnerable from a medical perspective.
2. There has been skepticism that managed care works as well for these beneficiaries as for healthy individuals, particularly because the needs of the former are greater and involve a more diverse set of providers.
3. Preventing hospitalizations or the need for long-term care can be a powerful cost reducer, and cost reduction for this group would be helpful since a very high proportion of Medicaid program costs are accounted for by a relatively small proportion of people with chronic illnesses and disability.

If states can work with their contracted plans to produce reliable encounter data, the state could focus on specific subgroups of Medicaid enrollees with special health care needs, answering basic questions that seem appropriate, albeit elusive with current data. For instance, how frequently are people with certain chronic illnesses visiting the emergency room or being hospitalized? Are people with developmental disabilities receiving dental care and preventive services at rates similar to the rates for others? Thus far, it has been difficult to produce reliable encounter data, although under the BBA, states must collect and submit these data to HCFA.[22,23] The major difficulty in producing complete and reliable data is that, under capitation from health plans, providers no longer need to submit claims for payment. Without this incentive, ambulatory care data in particular tend to be less complete and accurate.

Identifying the beneficiaries with special health care needs presents another challenge, again more easily met if there is reliable encounter data or ongoing screening to identify special needs. These individuals come into Medicaid through all eligibility pathways, not just through Supplemental Security Income eligibility.[32,33] Once the special needs population is identified, CAHPS supplemental survey questions on chronic illness and the increasing number of HEDIS measures for some of the most common chronic illnesses are examples of tools that can be used by states to assess quality and satisfaction.

In the end, however, states may conclude that, while monitoring quality for special needs populations in managed care is necessary, it will never be enough to ensure quality. There must be supportive program structures that pay enough for high-cost cases to prevent discrimination of or adverse financial impact on those who care for people with special health care needs. In addition, care coordination features built into the managed care program and strong mecha-

nisms for drawing out individual problems can go a long way in supporting (if not in measuring) quality for these vulnerable enrollees.

Measuring and Improving Quality for Beneficiaries in Fee-for-Service Medicaid

Much less effort has been devoted to ensuring and improving quality of care for beneficiaries in fee-for-service Medicaid than in managed care.[6] Without quality measurement on beneficiaries in fee-for-service programs, shortcomings found and addressed actively in managed care may be present or even worse under fee for service, without corresponding efforts to improve the problems. This is particularly worrisome where some geographic areas are wholly in managed care and some are wholly in fee-for-service care.* Quality-of-care risks exist under fee-for-service systems. For example, fee-for-service incentives for providers to increase utilization sometimes can lead to providers of the "Medicaid mill" type, who provide substandard care; there is no credentialing of providers to ensure they meet minimum quality standards; and the fee-for-service system does nothing to encourage preventive care or ensure a medical home. Without quality measurement, these issues remain largely hidden.

Critical Gaps in Knowledge

There is a critical gap in our understanding of what works in quality monitoring and improvement and what is cost effective and substainable. For the first time in the late 1990s, we began to know something about quality in Medicaid managed care, and states and health plans have been establishing systems and projects to improve quality for beneficiaries. These are important steps forward, but widespread variation in monitoring systems and in quality performance highlights the need to know which types of systems and projects are effective for ensuring and improving quality. For example, we know that many states and health plans are collecting HEDIS and CAHPS data for Medicaid, but are the data being used, and how is quality improving as a result? Is the sharing of HEDIS and CAHPS data (for example, in a "report card" format) an effective way to improve quality by affecting the behavior of beneficiaries and providers? Of the many state activities now in play, which are proving most effective?

The requirement in the BBA proposed rules that states periodically evaluate their quality improvement strategies offers an opportunity for states to step back

*Logic suggests that where managed care and fee-for-service delivery systems largely overlap, there may be spillover effects from managed care efforts to improve quality since providers generally do not differentiate how they practice by payment source of their patients.

from the press of monthly activities and identify changes that could improve both the effectiveness and the efficiency of their systems. There is no doubt that the time and resources for assessment-related activities such as these will compete with other demands; at the national level, we must hope this particular BBA requirement is given serious attention, and that the findings of these evaluations are shared among states.

Another challenge for states is to define their own responsibilities for quality assurance and improvement, those responsibilities that can be contracted, and those responsibilities that can be assigned to health plans. Knowing more about quality opens the door to improvement, but many improvements carry a price, at least in the short term. This long-standing tension over who bears the costs of improvement is not likely to abate as managed care plans face a generally difficult financial environment and seem to be turning away from the Medicaid program as both price and administrative requirements grow.

In conclusion, now that we have some basic tools for measuring quality, the most important next step may be to develop and disseminate better information about the relationships between the processes and projects designed to improve quality, health care outcomes, and costs. This kind of analysis and the dissemination of its results will help to ensure that the many quality assurance and improvement activities under way are cost effective and improve the health of beneficiaries.

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REFERENCES

1. The Kaiser Commission on Medicaid and the Uninsured. Medicaid facts: the Medicaid program at a glance. July 1999. Available at: http://www.kff.org. Accessed June 12, 2000.
2. Regenstein M, Schroer C. *Medicaid Managed Care for Persons with Disabilities: State Profiles.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured; December 1998.
3. US General Accounting Office. *Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area.* Washington, DC: US General Accounting Office; August 27, 1990. Publication GAO/HRD-90-81.

4. Epstein A. Medicaid managed care and high quality: can we have both? *JAMA.* November 19, 1997;278(19):1617–1621.
5. Verdier J, Young C. *Medicaid Managed Care Purchasing: What Works and What Doesn't.* Princeton, NJ: Center for Health Care Strategies; February 2000.
6. Landon B, Tobias C, Epstein A. Quality management by state Medicaid agencies converting to managed care. *JAMA.* January 21, 1998;279(3):211–216.
7. Institute of Medicine. *Medicare: a Strategy for Quality Assurance.* Vols. 1–2. Lohr K, ed. Washington, DC: National Academy Press; 1990.
8. Batalden PB, Buchanan ED. Industrial models of quality of medical care. In: Goldfield N, Nash DB, eds. *Providing Quality of Care: the Challenge to Clinicians.* Philadelphia, PA: American College of Physicians; 1989:133–159.
9. Berwick DM. Sounding board. Continuous improvement as an ideal in health care. *N Engl J Med.* January 5, 1989;320(1):53–56.
10. Health Care Financing Administration. Quality improvement system for managed care: interim standards. September 1998. Available at: http://www.hcfa.gov/quality/docs/qismc%2Ds.htm. Accessed June 12, 2000.
11. Agency for Healthcare Research and Quality, and CAHPS Consortium. CAHPS 2.0 questionnaires. Available at: http://www.ahcpr.gov/qual/cahps/cahpques.htm. Accessed June 12, 2000.
12. National Committee for Quality Assurance. HEDIS 2000 Health Plan Employer Data and Information Set. Available at: http://www.ncqa.org/pages/policy/hedis/h00meas.htm. Accessed June 12, 2000.
13. US Department of Health and Human Services, Health Care Financing Administration. Proposed rules Part 438, Subpart E, *Federal Register,* 63(188) (September 29, 1998).
14. US Department of Health and Human Services, Health Care Financing Administration. Proposed rules. *Federal Register,* 64(230):67223–67235 (December 1, 1999).
15. Felt-Lisk S, St. Peter R. *The Quality Assurance Reform Initiative (QARI) Demonstration for Medicaid Managed Care. Final Report.* Washington, DC: Henry J. Kaiser Family Foundation; November 1996.
16. Health Care Financing Administration. Quality improvement system for managed care: interim standards. September 1998. Available at: http://www.hcfa.gov/quality/docs/qismc%2Din.htm. Accessed June 12, 2000.
17. Partridge L, Johnson K. Monitoring the performance of managed care plans: state utilization of HEDIS. *Washington Memo.* January–February 1999;11(1):3–8.
18. Felt-Lisk S. Tools for monitoring quality for vulnerable populations. In: Lillie-Blanton M, Martinez R, Lyons B, Rowland D, eds. *Access to Health Care: Promises and Prospects for Low-Income Americans.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured; 1999:251–272.
19. Measuring Quality. Available at: http://www.facct.org. Accessed June 12, 2000.
20. Consumer Assessment of Health Plans (CAHPS): fact sheet. Available at: http://www.ahcpr.gov/qual/cahpfact.htm. Accessed June 12, 2000.
21. Gabel JR, Hunt KA, Hurst K. *When Employers Choose Health Plans: Do NCQA Accreditation and HEDIS Data Count?* New York: The Commonwealth Fund; September 1998.
21. Kaye N, Pernice C. Part I: key findings. In: Pelletier E, ed. *Medicaid Managed Care: a Guide for States.* 4th ed. Portland, ME: National Academy for State Health Policy; March 1999.
23. Wooldridge J, Hoag S. *The Perils of Pioneering: Medicaid Managed Care Monitoring.* Washington, DC: Mathematica Policy Research and The Urban Institute; December 1999.
24. Rosenbaum S, Sonosky C, Shaw K, Zakheim M. *Negotiating the New Health System: a Nationwide Study of Medicaid Managed Care Contracts.* 3rd ed. Washington, DC: Center for Health Services Research and Policy, The George Washington University Medical Center; June 1999.
25. Rosenbaum S, Shin P, Smith B, et al. *Negotiating the New Health System: a Nationwide*

Study of Medicaid Managed Care Contracts. 2nd ed. Washington, DC: Center for Health Services Research and Policy, The George Washington University Medical Center; 1997.

26. Aizer A, Felt-Lisk S, Nelson L. *Experience in Collecting Selected HEDIS 2.0 Measures for the Medicaid Population*. Washington, DC: The Henry J. Kaiser Family Foundation; 1996.
27. CAHPS User Stories. Available at: http://www.ahcpr.gov/qual/cahps/cahpuser.htm. Accessed June 12, 2000.
28. Pfahler M. External quality review organizations and the 1997 balanced budget act: issues for quality review of state Medicaid managed care programs. Draft issue brief for the Center for Health Care Strategies; February 2000.
29. Office of the Inspector General, US Department of Health and Human Services. *Lessons Learned from Medicaid's Use of External Quality Review Organizations* (OEI-01-98-00210). Boston, MA: Office of the Inspector General, September 1998.
30. Smith V, Des Jardins T, Peterson KA. *Exemplary Practices in Primary Care Case Management: a Review of State Medicaid PCCM Programs*. Princeton, NJ: Center for Health Care Strategies; July 2000.
31. Hurley R, McCue M. *Medicaid and Commercial HMOs: an At Risk Relationship*. Princeton, NJ: Center for Health Care Strategies; 1998.
32. Kronick R, Gilmer, T, Drefus T, Lee H. Improving payment for TANF and SSI Medicaid recipients: the chronic illness and disability payment system. *Health Care Financing Rev.* Spring 2000;21(3).
33. Felt-Lisk S, Mason M, Rosenbach M, Allen S. *Analysis of Nonelderly Medicaid Beneficiaries with Chronic or Disabling Conditions. Report Submitted to The Center for Health Care Strategies*. Washington, DC: Mathematica Policy Research; forthcoming.